Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

AMENDED MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SIERRA MEDICAL CENTER
C/O HEALTHCARE BUSINESS SERVICES
PO BOX 220010
EL PASO TX 79913-2010

Respondent Name

TEXAS MUTUAL INSURANCE COMPANY

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-98-D727-02

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The requestor did not submit a position statement for consideration.

Amount in Dispute: $6,970.82

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "… The Fund also contends that Petitioner's evidence fails to meet Petitioner's burden of proof to establish by a preponderance of the credible evidence that the Fund's reimbursement methodology falls short of the statutory standards for payment set forth above… Further, independent evidence established that the payment method used by the Fund provides payment o hospitals that equaled or exceeded the payment levels set in the statutory standards."

Response Submitted by: TWCIF, 221 West 6th Street, Suite 300, Austin, TX 78701-3403

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
November 26, 1997	Inpatient Hospital Services	$6,970.82	$0.00

FINDINGS AND DECISION

This **amended** findings and decision supersedes all previous decisions rendered in this medical payment dispute involving the above requestor and respondent.

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Former 28 Texas Administrative Code §133.305, effective June 3, 1991, 16 *Texas Register* 2830, sets out the

procedures for resolving medical fee disputes.

2. Former 28 Texas Administrative Code §134.401, effective August 1, 1997, 22 TexReg 6264, sets out the fee guidelines for acute care inpatient hospital services.
3. Former 28 Texas Administrative Code §134.600, effective April 1, 1997, 22 TexReg 1317, sets out the procedure for requesting pre-authorization of specific treatments and services.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
5. This request for medical fee dispute resolution was received by the Division on July 14, 1998.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - A – Preauthorization not obtained

Findings

1. 28 Texas Administrative Code §133.305(d)(7), effective June 3, 1991, 16 *Texas Register* 2830, requires that the request shall include "copies of all written communications and memoranda relating to the dispute." Review of the documentation submitted by the requestor finds that the request does not include a copy of any explanations of benefits or other written communications and memoranda pertinent to the dispute. The Division concludes that the requestor has not met the requirements of §133.305(d)(7).
2. 28 Texas Administrative Code §133.305(d)(10), effective June 3, 1991, 16 *Texas Register* 2830, requires that the request shall include "a summary of the requesting party's position regarding the dispute." Review of the documentation submitted by the requestor finds that the request does not include a summary of the requesting party's position regarding the dispute. The Division concludes that the requestor has not met the requirements of §133.305(d)(10).
3. The disputed services were denied with reason code A – "Preauthorization not obtained." 28 Texas Administrative Code §134.600(a), effective April 1, 1997, 22 TexReg 1317, states, in pertinent part, that "The insurance carrier is liable for the reasonable and necessary medical costs relating to the health care treatments and services listed in subsection (h) of this section, required to treat a compensable injury, when any of the following situations occur: (1) there is a documented life-threatening degree of a medical emergency necessitating one of the treatments or services listed in subsection (h) of this section; (2) the treating doctor, his/her designated representative, or injured employee has received pre-authorization from the carrier prior to the health care treatments or services." §134.600(h) states that "The health care treatments and services requiring pre-authorization are: (1) all nonemergency hospitalizations, ambulatory surgical center care, and transfers between facilities." Review of the submitted documentation finds that the provider did not document or support a life-threatening degree of medical emergency. No documentation was found to support that the disputed services were preauthorized. Therefore, the Division concludes that the denial reason is supported. No additional reimbursement is recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under 28 Texas Administrative Code §133.305. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Grayson Richardson	November 28, 2011
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.